



Send completed forms
to DOH Communicable
Disease Epidemiology
Fax: 206-361-2930

Haemophilus Influenzae

County _____

LHJ Use ID _____
☐ Reported to DOH Date ____/____/____
LHJ Classification ☐ Confirmed
☐ Probable
By: ☐ Lab ☐ Clinical
☐ Other: _____
Outbreak # (LHJ) _____ (DOH) _____

DOH Use ID _____
Date Received ____/____/____
DOH Classification
☐ Confirmed
☐ Probable
☐ No count; reason: _____

REPORT SOURCE

Initial report date ____/____/____
Reporter (check all that apply)
☐ Lab ☐ Hospital ☐ HCP
☐ Public health agency ☐ Other
OK to talk to case? ☐ Yes ☐ No ☐ Don't know
Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____ Birth date ____/____/____ Age _____
Address _____ ☐ Homeless Gender ☐ F ☐ M ☐ Other ☐ Unk
City/State/Zip _____ Ethnicity ☐ Hispanic or Latino
Phone(s)/Email _____ ☐ Not Hispanic or Latino
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____
Phone: _____
Occupation/grade _____
Employer/worksite _____ School/child care name _____
Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ____/____/____ ☐ Derived Diagnosis date: ____/____/____ Illness duration: ____ days

Signs and Symptoms

Y N DK NA

- ☐ ☐ ☐ ☐ Fever Highest measured temp: ____ °F
Type: ☐ Oral ☐ Rectal ☐ Other: ____ ☐ Unk
☐ ☐ ☐ ☐ Conjunctivitis
☐ ☐ ☐ ☐ Eyes sensitive to light (photophobia)
☐ ☐ ☐ ☐ Other symptoms consistent with illness: _____

Clinical Finding

Y N DK NA

- ☐ ☐ ☐ ☐ **Bacteremia**
☐ ☐ ☐ ☐ **Meningitis**
☐ ☐ ☐ ☐ **Pneumonia or pneumonitis**
X-ray confirmed: ☐ Y ☐ N ☐ DK ☐ NA
☐ ☐ ☐ ☐ **Epiglottitis**
☐ ☐ ☐ ☐ **Otitis media (otitis media alone does not meet the case definition for H. influenzae)**
☐ ☐ ☐ ☐ Cellulitis
☐ ☐ ☐ ☐ Pericarditis or pericardial effusion
☐ ☐ ☐ ☐ Osteomyelitis
☐ ☐ ☐ ☐ Septic arthritis
☐ ☐ ☐ ☐ Coma
☐ ☐ ☐ ☐ Admitted to intensive care unit
☐ ☐ ☐ ☐ Mechanical ventilation or intubation required during hospitalization

NOTES

Hospitalization

Y N DK NA

☐ ☐ ☐ ☐ **Hospitalized for this illness**

Hospital name _____
Admit date ____/____/____ Discharge date ____/____/____
Y N DK NA
☐ ☐ ☐ ☐ Died from illness Death date ____/____/____
☐ ☐ ☐ ☐ Autopsy

Vaccination

Y N DK NA

- ☐ ☐ ☐ ☐ Vaccine up to date for Hib
Date last vaccine prior to illness: ____/____/____
doses Hib vaccine prior to illness: ____
Vaccine series not up to date reason:
☐ Religious exemption
☐ Medical contraindication
☐ Philosophical exemption
☐ Previous infection confirmed by laboratory
☐ Previous infection confirmed by physician
☐ Parental refusal ☐ Under age for vaccination
☐ Other: _____
☐ Unk

Laboratory

Collection date ____/____/____

Y N DK NA

- ☐ ☐ ☐ ☐ **H. influenzae type b isolation (normally sterile site)** Site: _____
☐ ☐ ☐ ☐ **H. influenzae type b antigen positive (CSF)**

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count forward and backward to figure probable exposure and contagious periods

Days
from
onset:

Exposure period

-7 -1

o
n
s
e
t

Contagious period*

As long as organisms are present (may be prolonged)

Calendar dates:

* If treated, 24-48 hours after onset of effective antibiotic therapy

EXPOSURE (Refer to dates above)

Y N DK NA

☐ ☐ ☐ ☐ Travel out of the state, out of the country, or outside of usual routine
Out of: ☐ County ☐ State ☐ Country
Destinations/Dates: _____

Y N DK NA

☐ ☐ ☐ ☐ Contact with lab confirmed case
☐ Household ☐ Sexual
☐ Needle use ☐ Other: _____

Y N DK NA

☐ ☐ ☐ ☐ Does the case know anyone else with similar symptoms or illness

☐ Patient could not be interviewed

☐ No risk factors or exposures could be identified

Most likely exposure/site: _____

Site name/address: _____

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

PATIENT PROPHYLAXIS / TREATMENT

Y N DK NA

☐ ☐ ☐ ☐ Treated for nasopharyngeal carriage

PUBLIC HEALTH ISSUES

Y N DK NA

☐ ☐ ☐ ☐ Attends child care or preschool
☐ ☐ ☐ ☐ Do any household members work at or attend childcare or preschool
☐ ☐ ☐ ☐ Outbreak related

PUBLIC HEALTH ACTIONS

☐ Prophylaxis of appropriate contacts recommended
recommended prophylaxis: _____
receiving prophylaxis: _____
completing prophylaxis: _____

NOTES

Investigator _____ Phone/email: _____ Investigation complete date ____/____/____

Local health jurisdiction _____